Table 1: Provinces from which the CHWs were selected

Region	**Province**	**No. of CHWs**
ERO	Kabul	6
	Laghman	6
NRO	Balkh, Jawzjan & Samangan	6
	Kunduz	6
SRO	Ghazni	6
	Logar	6
Total		**36**

Table 2: Age distribution of the CHWs

Age	<20Y	21-30Y	31-40Y	41-50Y	50Y and above	No answer	Total
Number	4	13	12	4	1	2	36
Percentage	11.12%	36.12%	33.34%	11.12%	2.78%	5.56%	100%

Table 3: Training level of CHWs in different regions

Region	Module I	Module II	Module III	Refresher	Not specified	Total
ERO	0	0	8	4	0	12
NRO	1	7	1	0	3*	12
SRO	4	0	2	6	0	12
Total	5	7	11	10	3	36
Percentage	13.89%	19.45%	30.56%	27.78%	8.34%	100%

Table 4: Training level of female and male CHWs

Sex	Module I	Module II	Module III	Refresher	Not specified	Total
Female	5	0	4	0	3*	12
Male	0	7	7	10	0	24
Total	5	7	11	10	3	36
Percentage	13.89%	19.45%	30.56%	27.78%	8.34%	100%

*The 3 females in NRO were recruited recently. They had not attended any CHW course.

Table 5: Number of households covered by female and male CHWs

No. of households	<300	300-600	601-1200 and above	No answer	Total
Female	3	4	4	1	12
Male	5	3	16	0	24
Total	8	7	20	1	36
Percentage	22.23%	19.45%	55.56%	2.78%	100%

Average activities of CHWs

Table 6: Average activities of CHWs:

No. of CHWs	Households visited last month	Patients referred last month	People referred for vaccine last month	Wells improved since beginning the work	Karizes improved since beginning the work	Springs improved since beginning the work	Other sources of water improved since beginning the work	Latrines improved since beginning the work	Water reservoirs drained since beginning the work	Number of health education sessions at school last month	No. of health education sessions at mosque last month	Avg of households answered correctly >50% of the questions
36	9	18	29	24	0	0	5	5	2	2	7	1

Table 7: Average activities of CHWs with a breakdown into male and female:

SEX	No. of CHWs	Households visited last month	Patients referred last month	People referred for vaccine last month	Wells improved since beginning the work	Karizes improved since beginning the work	Springs improved since beginning the work	Other sources of water improved since beginning the work	Latrines improved since beginning the work	Water reservoirs drained since beginning the work	Number of health education sessions at school last month	No. of health education sessions at mosque last month	Avg of households answered correctly >50% of the questions
F	12	11	17	21	13	0	1	2	8	3	1	0	1
M	24	8	19	34	29	0	0	6	4	2	3	11	1

Table 8: Average of activities of CHWs in different regions:

REGION	No. of CHWs	Households visited last month	Patients referred last month	People referred for vaccine last month	Wells improved since beginning the work	Karizes improved since beginning the work	Springs improved since beginning the work	Other sources of water improved since beginning the work	Latrines improved since beginning the work	Water reservoirs drained since beginning the work	Number of health education sessions at school last month	No. of health education sessions at mosque last month	Avg of households answered correctly >50% of the questions
ERO	12	11	11	34	19	0	1	1	4	2	2	8	2
NRO	12	7	28	37	33			13	8	2	4	6	1
SRO	12	7	16	17	19	0	1	0	4	2	0	7	1

Table 9: Average of CHW activities with a breakdown among those who are supervised and those who are not supervised:

Supervised ?	No. of CHWs	Households visited last month	Patients referred last month	People referred for vaccine last month	Wells improved since beginning the work	Karizes improved since beginning the work	Springs improved since beginning the work	Other sources of water improved since beginning the work	Latrines improved since beginning the work	Water reservoirs drained since beginning the work	Number of health education sessions at school last month	No. of health education sessions at mosque last month	Avg. of households answered correctly >50% of the questions
No	3	11	17	31	8					2		13	0
Yes	33	8	18	29	25	0	0	5	6	2	2	7	1

Table 10: Average of CHW activities with a breakdown among those who are permanent residents of the catchment area and those who are not:

Permanent resident?	No. of CHWs	Households visited last month	Patients referred last month	People referred for vaccine last month	Wells improved since beginning the work	Karizes improved since beginning the work	Springs improved since beginning the work	Other sources of water improved since beginning the work	Latrines improved since beginning the work	Water reservoirs drained since beginning the work	Number of health education sessions at school last month	No. of health education sessions at mosque last month	Avg. of households answered correctly >50% of the questions
N	4	7	11	23	21	0	0	2	6	1	3	4	2
Y	31	9	19	31	25	0	0	5	5	2	2	8	1

Table 11: Average of CHW activities with a breakdown among those who had had experience in the fields related to health:

Previous experience in health?	No. of CHWs	Households visited last month	Patients referred last month	People referred for vaccine last month	Wells improved since beginning the work	Karizes improved since beginning the work	Springs improved since beginning the work	Other sources of water improved since beginning the work	Latrines improved since beginning the work	Water reservoirs drained since beginning the work	Number of health education sessions at school last month	No. of health education sessions at mosque last month	Avg. of households answered correctly >50% of the questions
No	21	8	19	21	23	0	1	7	6	2	2	5	1
Yes	15	9	16	41	24	0	0	1	4	2	2	10	1

Table 12: Average of activities of CHW at different levels:

Level	No. of CHWs	Households visited last month	Patients referred last month	People referred for vaccine last month	Wells improved since beginning the work	Karizes improved since beginning the work	Springs improved since beginning the work	Other sources of water improved since beginning the work	Latrines improved since beginning the work	Water reservoirs drained since beginning the work	Number of health education sessions at school last month	No. of health education sessions at mosque last month	Avg. of households answered correctly >50% of the questions
Module I	5	10	9	20	20		1	1	5	1	2	1	1
Module II	7	7	30	50	52			20	7	1	4	11	1
Module III	11	7	12	18	8	0	0	0	3	3	2	7	1
Refresher	10	10	15	34	27	0	0	1	3	3	2	10	2

Table 13: Average activities of CHWs with different educational background:

Education	No. of CHWs	Households visited last month	Patients referred last month	People referred for vaccine last month	Wells improved since beginning the work	Karizes improved since beginning the work	Springs improved since beginning the work	Other sources of water improved since beginning the work	Latrines improved since beginning the work	Water reservoirs drained since beginning the work	Number of health education sessions at school last month	No. of health education sessions at mosque last month	Avg. of households answered correctly >50% of the questions
Secondary school	10	10	9	27	24	0	0	2	7	2	3	7	1
High school	23	9	22	30	25	0	0	6	4	1	2	8	2
Higher education	3	4	13	29	13		0	2	7	8	4	4	2

Total activities of CHWs:

Table 14: Total activity of the CHWs:

No. of CHWs	No. of households visited Last Month	No. of patients referred last month	No. of people referred for vaccinations	Involved in the improvement of wells since employment	Involved in the improvement of Karizes since employment	Involved in the improvement of springs since employment	Involved in the improvement of other water sources since employment	Involved in the construction of Latrines since employment	Involved in the drainage of water reservoirs since employment	No. of health education sessions held at schools	No. of health education sessions conducted at mosques	No. of families answered more than 50% out of 36
36	312	649	1059	846	3	14	166	188	75	78	258	48

Table 15: Total activity of the CHWs per region

Region	No. of CHWs	No. of households visited Last Month	No. of patients referred last month	No. of people referred for vaccinations	Involved in the improvement of wells since employment	Involved in the improvement of Karizes since employment	Involved in the improvement of springs since employment	Involved in the improvement of other water sources since employment	Involved in the construction of Latrines since employment	Involved in the drainage of water reservoirs since employment	No. of health education sessions held at schools	No. of health education sessions conducted at mosques	No. of families answered more than 50% out of 36
ERO	12	136	128	410	222	0	6	9	47	26	23	92	25
NRO	12	87	331	445	396			155	99	21	53	77	12
SRO	12	89	190	204	228	3	8	2	42	28	2	89	11
Total	**36**	**312**	**649**	**1059**	**846**	**3**	**14**	**166**	**188**	**75**	**78**	**258**	**48**

Table 16: Total activity of the CHWs per sex

Sex	No. of CHWs	No. of households visited Last Month	No. of patients referred last month	No. of people referred for vaccinations	Involved in the improvement of wells since employment	Involved in the improvement of Karizes since employment	Involved in the improvement of springs since employment	Involved in the improvement of other water sources since	Involved in the construction of Latrines since employment	Involved in the drainage of water reservoirs since employment	No. of health education sessions held at schools	No. of health education sessions conducted at mosques	No. of families answered more than 50% out of 36
F	12	131	198	248	154	0	7	18	97	32	17	5	17
M	24	181	451	811	692	3	7	148	91	43	61	253	31
Total	**36**	**312**	**649**	**1059**	**846**	**3**	**14**	**166**	**188**	**75**	**78**	**258**	

Table 17: Total activity of the CHWs who are supervised and not supervised

Supervised	No. of CHWs	No. of households visited Last Month	No. of patients referred last month	No. of people referred for vaccinations	Involved in the improvement of wells since employment	Involved in the improvement Karizes since employment	Involved in the improvement of springs since employment	Involved in the improvement of other water sources since	Involved in the construction of Latrines since employment	Involved in the drainage of water reservoirs since employment	No. of health education sessions held at schools	No. of health education sessions conducted at mosques	No. of families answered more than 50% out of 36
No	3	32	50	92	25					6		40	1
Yes	33	280	599	967	821	3	14	166	188	69	78	218	47
Total	**36**	**312**	**649**	**1059**	**846**	**3**	**14**	**166**	**188**	**75**	**78**	**258**	

Table 18: Total activity of the CHWs who are native residents and those who are not native residents

Native resident	No. of CHWs	No. of households visited Last Month	No. of patients referred last month	No. people referred for vaccinations	No. of wells improved	No. of Karizes improved	No. of springs improved	No. of other water resources improved	Latrines constructed	No. of water reservoirs drained	No. of health education sessions held at schools	No. of health education sessions conducted at mosques	No. of families answered more than 50% out of
DNK	1	10	20	7	3					1			
N	4	28	45	91	83	0	1	6	23	5	12	16	
Y	31	274	584	961	760	3	13	160	165	69	66	242	
Total	**36**	**312**	**649**	**1059**	**846**	**3**	**14**	**166**	**188**	**75**	**78**	**258**	

Table 19: Total activity of the CHWs with previous experience

Previous experience in health	No. of CHWs	No. of households visited Last Month	No. of patients referred last month	No. people referred for vaccinations	No. of wells improved	No. of Karizes improved	No. of springs improved	No. of other water resources improved	Latrines constructed	No. of water reservoirs drained	No. of health education sessions held at schools	No. of health education sessions conducted at mosques
N	21	175	408	448	485	2	11	151	128	46	44	101
Y	15	137	241	611	361	1	3	15	60	29	34	157
Total	**36**	**312**	**649**	**1059**	**846**	**3**	**14**	**166**	**188**	**75**	**78**	**258**

Table 20: Total activity of the CHWs with different training levels in CHW modules

LEVEL	No. of CHWs	No. of households visited Last Month	No. of patients referred last month	No. people referred for vaccinations	No. of wells improved	No. of Karizes improved	No. of springs improved	No. of other water resources improved	Latrines constructed	No. of water reservoirs drained	No. of health education sessions held at schools	No. of health education sessions conducted at mosques
Not indicated	3	36	105	70	23			15	42	5	3	
Module I	5	52	45	99	102		7	3	25	6	12	5
Module II	7	48	208	352	366			137	52	8	26	75
Module III	11	78	137	201	87	0	5	3	37	29	20	79
Refresher	10	98	154	337	268	3	2	8	32	27	17	99
Total	36	312	649	1059	846	3	7	166	188	75	78	258

Table 21: Total activity of the CHWs with different educational background

Education	No. of CHWs	No. of households visited Last Month	No. of patients referred last month	No. people referred for vaccinations	No. of wells improved	No. of Karizes improved	No. of springs improved	No. of other water resources improved	Latrines constructed	No. of water reservoirs drained	No. of health education sessions held at schools	No. of health education sessions conducted at mosques
Secondary school	10	99	92	274	239	3	4	19	69	21	29	73
High school	23	201	517	697	567	0	9	142	99	31	37	173
Higher education	3	12	40	88	40		1	5	20	23	12	12
Total	36	312	649	1059	846	3	14	166	188	75	78	258

Introduction

The Swedish Committee for Afghanistan (SCA) for nineteen years has been involved initially in providing emergency relief support and then development cooperation work in Afghanistan.

The objective of the SCA health program is to provide comprehensive Primary Health Care presently through 169 clinics, including 4 EOCs, in under-privileged rural areas in 19 provinces of Afghanistan. The program aims at basic health services and rehabilitation, with special emphasis on promotive and preventive measures, basic mother and child health care, community based health activities and community participation. To this end, SCA health unit initiated the Community Health Workers (CHWs) program in July 1996. The CHWs have been trained in SCA training units and are attached to the clinics. At the beginning there were two CHWs per C1 and one per C2 clinics. Later (1998) their number was increased to three CHWs per C1 clinics and two CHWs per C2 clinics (a total of 387 CHWs at the time of evaluation)

A CHW trainee is to be introduced by the community where he/she is to work. CHWs are trained to function in the community in close relationship with the health care system. Thus, along with other community based health workers, CHWs are to act as a bridge, between the community and health care system.

In Afghanistan 80% of the population live in rural areas. Large segments of the rural population have no easy access to health facilities and even though new facilities may be established, these can not adequately be expected to cover large dispersed populations. CHWs, may offer a potential solution to the problem of reaching under-served populations. In-addition, the use of CHWs is presumably more cost effective than the use of facility-based paraprofessionals. It is also expected that by using community members to deliver service and support, the social and cultural barriers which keep people from using health services and support can be overcome and community can be stimulated to accept responsibility for their own health and well-being.

This evaluation has been undertaken in a positive spirit. We believe that the CHW program is a new initiative in the health program and that in the years to come they will serve as an effective mean in the further improvement of the preventive and promotive components of health program. This evaluation was designed to investigate more about the value of CHWs. For the purpose of making more informed decisions, the aim was to gather reliable and valid information about CHWs in a systematic way.

We hope that this report will provide the SCA health management team with background information for further discussion on improvement of community based activities in general and performance of CHWs in special.

Let me take this opportunity and express sincere thanks to numerous persons who contributed in many ways to the evaluation of the CHWs activities and performance. We have tried to conduct the evaluation in a participatory way and the participants should be congratulated for their efforts that ensure, through the evaluation, the health program improvement and strengthening. Thanks to the entire health team in HTSU and RHUs who contributed their time, insight and suggestions to the evaluators.

I wish to thank the following individuals who had key role in evaluation planning, data collection, compilation and analysis of the reports:

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At the end I would like to request the readers to give us their constructive comments and recommendations about the evaluation and for further improvement of the program in future.

Dr. Roohullah Roohian Shabon
Chief Technical Advisor, Health

Objectives

- Evaluating the activity of the CHWs.
- Analyzing the level of the CHW activities considering factors like gender, local platform and education
- Assessing the knowledge and practices of people reached by CHWs.
- Exploring the problems and finding ways for improvement of the CHW program.

Rational

Based on the Minimum Primary Health Care Framework, SCA initiated the CHW program in 1996. During the time of evaluation, SCA had 387 (87 females and 300 males) active CHWs. It was on high demand to survey and evaluate the activities of the CHWs, to define the problems and explore ways for improvement of the program.

Methodology

Study design
Cross sectional.

Subjects
Community health workers and families in the catchment area of respective CHWs.

Variables
1. CHWs. Age, sex, region, educational background, experience in health before receiving CHW training, level in CHW training, CHW workplan, CHW kit, number of the households covered by the CHW, number of the health education sessions conducted by CHWs during the last month, number of the home visits in the last month, number of the patients referred by the CHW in the last month, participation of the CHW in different campaigns, supervision of the CHW, main problems of the CHWs, need for further training of CHWs.
2. Families reached by CHWs. Knowledge and practices of the people reached by the CHW during homevisits.

Sampling
The three regions were considered as three strata. Each region was divided into five clusters, and then two clusters from each region were selected randomly. Four females and 8 male CHWs were selected randomly in each cluster for evaluation with a total of 36 CHWs (see table 1).

For household interviews, three households per CHW were selected randomly from those that, according to the CHWs, had been visited by the CHWs during the month before the evaluation.

Data collection
A structured questionnaire was developed to record the views of the respondents. The questionnaire had two parts. The first part was intended to be answered by the CHWs. It contained questions about the background of the CHWs; their catchment area and activities. The second part was filled during the interview with the households. There were some questions for assessing the knowledge and practices of the households regarding certain health issues.

Prior to the commencement of the survey a training workshop for the interviewers was conducted in Kabul. There were 6 interviewers (one trainer and one supervisor per region). During the workshop the participants were oriented on their role and task, sampling method, interview techniques and filling of the questionnaire. After the theoretical training, participants of the workshop did a field test – interviewing some CHWs and households and pre-testing the questionnaire – in four different sites in Kabul province. Based on the lessons learned from the practical work, some minor changes were brought into the questionnaire. Then, according to plan, the evaluation was conducted in all three regions.

Findings

Background of the CHWs (selection and training)
As illustrated in table 2 the CHWs were selected from different age groups, the majority (69%) being 20-40 years old.

Four out of 36 CHWs (11.12%; three from ERO and 1 from NRO) were not living in the catchment area of their corresponding clinics. Table 10 displays some differences in the activities of the CHWs in favor of those who are the inhabitants of their catchment area. However, due to small number of the CHWs who are not living in the catchment one cannot say if the difference is significant.

15 out of 36 CHWs (41.67%; 6 from ERO, 3 from NRO and 6 from SRO) had had experience in the fields related to health before receiving CHW training. The figures in table 11 show that the CHWs with previous experience have referred more people for vaccination and conducted more health education sessions. However, in other fields of activity no difference was revealed.

26 of the CHWs (72.23%; 11 from ERO, 9 from NRO and 6 from SRO) had diploma from high school or had higher education. The rest had graduated from secondary school. As indicated by the figures in table 13 the CHWs with higher education may be more successful in conveying health messages to families. The difference is however not significant and generally the two groups of CHWs display almost the same level of activity.

As illustrated in tables 3, all the CHWs in ERO have finished all the training modules while in SRO and NRO, they are seemingly lugging behind. In NRO there were 3 CHWs who were recently recruited without preceding CHW training. Two third of the females (66.66%) had studied only module I or had not received any training at all (table 4). An interesting finding is that improvement and increase of activities have not accompanied the training with modules II and III. Just those who have received refresher training demonstrate a difference in the number of families who scored higher than 50% (see table 12)

7 of the CHWs (19.45%; 3 in NRO and 4 in SRO) answered that they had no CHW kit. 14 of them (38.89%; 4 in ERO, 3 in NRO and 7 in SRO) had incomplete kits.

Performance of the CHWs:
The number of the households covered by female and male CHWs respectively is illustrated in table 5.

The minimum number of households covered by a CHW is an estimated 100, and the maximum 5000 households. The average is 1190 and the mode is to be 300-1200 (three fourth of the CHWs). Dividing the number of the CHW catchment households by the number of households visited last month, it was found that they would be able to visit all their households once within 9.75-750 months.
30 out of 36 (83.34%) had a monthly actionplan.
35 out of 36 (97.23%) prepare a monthly report.
17 out of 36 (47.23%) had prepared a map of the clinic catchment area.
33 out of 36 (91.66%) were supervised by the staff of the clinic.

29 out of 36 (80.56%) were visiting the households. The seven CHWs who have not visited any household were all males (1 in ERO, 2 in NRO and 4 in SRO).
24 (9 female and 15 male) out of 36 (66.6%) had visited less than 15 households during the month before the evaluation. The overall average of the homevisits per month was 9 (11 for females and 8 for males; 11 in ERO, 7 in SRO and 7 in NRO). The maximum was 30 and the mode 20.

On average the CHWs during the month before the evaluation referred 18 patients to their respective clinic and 29 women and children for vaccination. Even those who were not doing homevisits said that they have referred patients, women and children. The minimum of patients referred during the last month was 0. The maximum was 70. The mode was 20. The minimum of children and women referred for vaccination was 0, the maximum was 150, and the mode was 20.

22 of the CHWs (61.12%, including one female CHW from SRO) conduct health education sessions at mosques. The average number of the health education sessions conducted by these CHWs at mosques per month was 11.7. The overall average was 7.16, the minimum 0 and the maximum 25. The mode was 10.

27 CHWs (including 5 females) out of 36 (75%) were conducting health education sessions at schools. At the time of the evaluation most of the schools were closed due to winter holidays. 14 CHWs had conducted health education during the month before the evaluation. The average number of sessions per these CHWs per month was 6. The minimum was 0 and the maximum 15. The mode was 6.

27 of the CHWs (75%) have participated in NIDs. 5 of them (14%) had participated in CDD campaigns. They had not taken part in ARI or nutrition campaigns as:

- they had not been invited: 9 CHWs in NIDs
- the campaigns had not been conducted at all: 30 CHWs' account for other campaigns.

16 of them (44.45%) have reported the occurrence of epidemics in their area and have taken part in their control.

31 of the 36 CHWs (86.12%) had been involved in the improvement of a total of 1029 water sources (846 well, 3 Karizes, 14 springs and 166 other sources of water) since the start of their work. The average was 33 water sources per CHW, the minimum 0 and the maximum was 120. The mode was 5.
21 of them (58.34%; 6 from ERO, 12 from NRO and 3 from SRO) had since their employment started been involved in building 188 closed latrines. The average was 9 latrines for these CHWs. The minimum was 0, the maximum 30, and the mode 5 latrines per CHW.
16 of the CHWs (44.45%) had been involved in the drainage of stagnant water.
35 of them (97.23) have taken part in improving waste disposal.

Problems perceived by CHWs

24 (66.67%) of them have complained that they have too many households to cover.

Two of the CHWs (5.56%) said that the people did not accept the program and their activities.

7 of the CHWs (19.45%) complained about problems with transportation.

Two of the CHWs (5.56%) said that one bicycle is not enough for two CHWs.

10 of them (27.78%) said that their salary level was too low.

Two of the CHWs (5.56%) complained that they did not have any health education material.

Two female CHWs said that they could not bring a Maharam during homevisit.

One of the CHWs, from Kunduz province, expressed problems of security.

CHW's views on their training and the curriculum used:
Most of the CHWs who had received module I training said that they expected to be approached also for upgrading module II, III and refresher training.

22 of the CHWs (61.12%) thought that the current curriculum was sufficient. 13 of them said that it would not be enough. Four of them have made the following suggestions:

- One CHW suggested that first aid should be included in the training.
- One CHW suggested that more details should be given about acute respiratory infections.
- One CHW wanted training regarding cholera and cholera outbreaks.
- One CHW wanted training about adverse effects of drugs.

The suggestions of the CHWs for the improvement of their program:

- Seven CHWs suggested that flipcharts and other Health Education material should be provided
- Three CHWs suggested an increase in their salary
- Three CHWs suggested that they should be provided additional training, but did not specify which courses and what topics.

Households visited by the CHWs during the last month
Three households per CHW (for those who were doing home visits) that have been visited by CHWs them were interviewed by the evaluators. In total 74 households were visited by the interviewers. The following information was elicited from the visits:

<u>*Households visited by the CHWs during the last six months:*</u>
29 households (38%) of them have been visited less than 5 times.
44 (57%) of them have been visited 5-14 times.
4 (5%) of them have been visited >15 times.
Maximum number of visits: 24; Minimum number of visits: 1; Average number of visits 7.
The mode was: 6.

Knowledge about weaning of infants:
39 families (52.7%) knew when to start weaning food for infants.
35 families (47.3%) did not know when to start weaning food for infants.

Knowledge about vaccination of children:
53 families (71.63%) knew when a child should be vaccinated for the first time
21 families (28.38%) did not know.

Hygienic handling of food:
45 families (60.81%) knew how to wash vegetables.
29 families (29.19%) did not know how to wash vegetables.

Environmental sanitation:
54 families (72.9%) knew how to safely dispose the garbage.
19 families (25.7%) did not know how to safely dispose the garbage.
1 family (1.4%) had given no answer.

Safe drinking water:
62 families (83.79%) knew how to make water safe for drinking.
12 families (16.21%) did not know it.

Control of Diarrheal Diseases, CDD:
46 families (62.17%) knew how to prepare ORS solution.
28 families (37.83%) did not know it.

Management of Acute Respiratory tract Infections, ARI:
46 families (62.17%) knew when to take a child with cough to a doctor
28 families (37.83%) did not know it.

Control of Malaria:
37 families (50%) knew how to prevent malaria
37 families (50%) did not know.

The hygiene of the children:
The hygiene of the children was OK (i.e. the clothes, hair, hands, and feet were clean and the nails were cut short) in 31 families (41.9%).
The hygiene of the children was not OK in 38 families (51.36%).
It was not specified in five families (7.74%).

The cleanliness of the yard:
The yard was clean in 29 houses (39.19%).
It was not clean in 43 houses (58.11%).
It was not specified in 2 houses (2.7%).

Vaccination records:
Vaccination cards of women and children available and updated in 25 families (33.79%).

They were not available or updated in 45 families (60.81%).
Water source:
55 families (74.32%) were using water from well.
2 families (2.7%) were using Karizes.
17 families (22.98%) got water from other sources.

The condition of the well:
37 of those who are using wells had covered wells (67.28%).
The wells of the remaining 18 families (32.72) were uncovered.

Latrines: closed or open?
9 families (12.17%) had closed vault latrines.
65 families (87.83%) had open latrines or used no latrine at all.

Discussions and Conclusions

Mostly the high frequency of morbidity and premature mortality in Afghanistan is related to factors that may be counteracted by health education, proper EPI and improved water and sanitation. SCA very much emphasize the importance of preventive measures. To this end the community based health workers play a role just as important as that of clinic based health workers.

The selection criteria for CHWs have been elaborated based on a desk study and some field experience. The evaluation shows that the criteria set has not always been followed and that there is some need for revision.
Some of the CHWs included in the evaluation had no previous training at all before taking on their responsibilities. At the same time the results of the evaluation questions whether it is a true asset for a CHW to have a background as a (curative) health worker. It would in this regard be interesting to compare the output of those CHWs as compared to schoolteachers who have received CHW training.

The evaluation reveals that CHWs who have been refresher trained have a higher level of activity as compared to those with less training. The reason for this could be several including that the refresher trained CHW *per se* have gained more experience. It is also a fact that the refresher training is all practical, conducted in the field. A conclusion of the evaluators is that the CHW training should be revised so that Module I-III include much more practical moments.
The evaluation also suggests that some topics should be given special attention, such as the EPI and how to practically help the households to improve the level of hygiene and sanitation.

The SCA supported health facilities are staffed with CHWs according to an estimated catchment area and target population (C1: 30,000-50,000, and C2: 15,000-30,000). As yet this structure is incomplete, i.e. there is an ongoing process with downgrading, upgrading, relocation (and closure) of clinics. Thus, not all clinics match the stipulated criteria. The evaluation has highlighted the need to develop specified targets for individual CHWs. This is likely to improve the focus of the CHW activities as well as facilitate the future supervision, follow up, verification and evaluation of the CHW activities.
Although not specified, the evaluators had some expectations regarding the level of activity by the CHW and the actual output. The number of health education sessions in schools and mosques did well match the expectations, i.e. at average 11 such sessions per month, although the number of such sessions was much lower per female CHW (only one per month) than anticipated.

The number of household visited was much lower than expected, at average only nine per month (about a third of the expected output). The same is true for the expected impact. The reasons may be manifold, such as not following guidelines for selection of CHW trainees, inappropriate training in community mobilization, difficulties with monitoring especially in the more remote parts of the catchment areas etc.

Generally, the CHWs in ERO were making more homevisits as compared to their colleagues in SRO and NRO. Besides, the number of the families who scored more than 50% were higher in ERO. It can be attributed to different things such as the people in ERO (Kabul and Laghman) being generally more educated. Also, ERO has been more active in conducting training sessions for CHWs than SRO and NRO, male and females, including higher training (in module III or refresher).

The reason(s) why the female CHWs included in the evaluation did not visit a significant higher number of households than the male CHW is not explained in this study. One may speculate that they may face more transportation problems than their male colleges. Two of the 87 females interviewed spontaneously stated that they had perceived problems for their maharam during homevisits. Also, the total number of female CHWs included was small (4 per region) and the results may not be representative.

One reason for the low output may be an insufficient supervision of the CHWs regarding their community-based activities. 92% of the CHWs stated that the staff of the clinic had supervised them. The evaluation, however, does not show how frequent of this supervision has been or how it has been carried out. Especially the more remote parts of respective catchment area leave a question mark in this regard.

Almost all CHWs (97%) have stated that they have declared their activities in monthly reports. There is a definite need to develop a proper follow up and system for feed back of the information gathered by the CHWs. That information should also encompass symptoms of EPI related diseases and mortality figures.
To this end the *female* CHW may play a key role. In Afghanistan more than 90% of all deliveries take place at home, and so do the majority of the premature deaths of mothers and children. Thus, there is a need to take into account the special conditions in which the female CHWs operate and ensure that (also) they and their work is properly introduced in the local communities (by CHC members, health workers at respective clinic or staff from the SCA regional health unit).

Recommendations

The present guidelines for selection of CHW trainees (see annex...) should be revised.
Priority should be given to
- those who living in the catchment area of the clinic
- candidates with at least 8 years of basic schooling
- females

Plan to elaborate minimum standards in various fields of CHW activities like
- the number of households to be covered by each CHW, e.g. 200 households/year/CHW
- minimum number of health education sessions at mosques, e.g. 1 session/week/CHW
- minimum number of health education sessions in schools, e.g. 1 session/week/CHW
- number of health education sessions in clinic, e.g. 1 day/week/CHW

Job description of CHWs should be revised regarding
- <u>Actionplan for the individual CHW</u>
- <u>EPI related activities</u>:
  - strengthen the need for active participation of the CHWs in the EPI
  - specify that CHWs must check the immunization status of the members of the households that they are visiting

- not fully immunized children and women in target ages must be referred, either to EPI fixed center or to vaccinators during outreach.

The reporting format of CHWs should be revised to include
- quantitative activity variables such as the number of homevisits, number of health education sessions in various places, etc.
- mortality among children and pregnant women/mothers in the villages
- cases presenting with EPI related diseases

The training scheme of the CHWs to be revised
- more practical training to be included in module I-III, including on job training
- more skills regarding community mobilization

An evaluation of the CHW program should be repeated in regular intervals. It is recommended that the next evaluation should cover other aspects of the program, including the competence of the CHWs and should employ different methodologies such as group discussions to allow in-depth examination. Control households should also be interviewed for making comparisons.

Limitations

Since there was no control site, no baseline survey was done before the program and there are numerous cofounders it was not possible to measure the impact of the CHWs.
The knowledge and healthy practices of the families are not necessarily related to the activities of the CHWs.
As only families and schools visited by the CHWs are included in the study, therefore they cannot represent the whole community.
Mosques and other kinds of gathering, which seems to be used by CHWs especially the male ones for conveying their messages, are difficult to be included in the study in terms of time and logistics. This means this study probably has ignored an important field of CHW activities.
All CHW must be provided a proper CHW kit by the time they start their activity in the field.